

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034470

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 2687

FILED SEP 4 1963

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CLAYTON</b>		c. CITY OR TOWN <b>EUREKA</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS COUNTY HOSP</b>		d. STREET ADDRESS (If outside, give location) <b>324 HEYDEN DR</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES D KOONS</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 26 1963</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 3, 1948</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>15</b>
11. BIRTHPLACE (City and state or country) <b>ST. LOUIS MO.</b>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <b>KENNETH KOONS</b>		13b. MOTHER'S MAIDEN NAME <b>NOMA MILTON</b>	
14. NAME OF HUSBAND OR WIFE <b>-</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. INFORMANT <b>KENNETH KOONS 324 HEYDEN DR.</b>		17. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Damage</b> DUE TO (b) <b>Gunshot wound of the head</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Gunshot wound of head</b>		20c. TIME OF INJURY Hour <b>2:45</b> p.m. Month, Day, Year <b>8/26/63</b>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>bedroom of home</b>	
20f. CITY, TOWN, OR LOCATION <b>Eureka</b>		COUNTY <b>St. Louis</b> STATE <b>Missouri</b>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>9:45 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Raymond E. Hand</b> Coroner		22b. ADDRESS <b>Clayton, Missouri</b>	
22c. DATE SIGNED <b>8/30/63</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
23b. DATE <b>AUG 30, 1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEMETERY</b>	
23d. LOCATION (City, town, or county) <b>JEFFERSON BARRACKS MO.</b>		23e. DATE RECD. BY LOCAL REG. <b>8-27-63</b>	
23f. REGISTRAR'S SIGNATURE <b>John B. Murphy</b>		23g. ADDRESS <b>Thomas Kutis 2906 Gravois</b>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR

TYPEWRITER RIBBON

County Board

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.